PATIENT INFORMATION FORM

(PLEASE PRINT)

PATIENT NAME: ____ DATE OF BIRTH: ____________________

GENDER: Female / Male PATIENT'S SS #: ________________________

RACE: ___White/Caucasian ___Native American ___Hawaiian Native/Pacific Islander ___Black/African American ___Asian

OTHER: _______________________________________

ETHNICITY: ___Hispanic ___Non-Hispanic

Preferred Language: ________________________________

PARENT #1 PHONE: __________________________

PARENT #2 PHONE: __________________________ or FOSTER PARENT/GUARDIAN PHONE:_____________________

ADDRESS: _____________________________________

CITY: _______________________ STATE: __________ ZIP: _______________

RESPONSIBLE PARTY (Guarantor): ___________________________

Insurance Holder name if Different: ___________________________

INSURANCE COMPANY: ____NUMBER: ______________________________

DOB Of Insured: _______________RELATIONSHIP: ___Mother ___Father OTHER: ______________

PARENT #1: _______________________________________ MOTHER / FATHER / GUARDIAN

DOB: ____________________________ SS#: ______________________

ADDRESS if different: ___________________________

CITY: _______________________ STATE: __________ ZIP: _______________

Place of Employment: ____ PHONE # ______________________

PARENT #2: _______________________________________ MOTHER / FATHER / GUARDIAN

DOB: ____________________________ SS#: ______________________

ADDRESS if different: ___________________________

CITY: _______________________ STATE: __________ ZIP: _______________

Place of Employment: ____ PHONE # ______________________

Preferred Email for Patient Portal: ____

Where would you like your statements sent: MAIL or PATIENT PORTAL

Will we be your PRIMARY CARE PROVIDER or is this a WALK-IN ONLY visit?

Who may we contact other than a Parent/Guardian, In case of Emergency:

____ Phone #: _______________________

Relationship to Patient: _________________________________

Additional Family Members Seen In Our Office: ____

HOW DID YOU HEAR ABOUT US? ____